STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX
XXXXXX
Petitioners

v **File No. 121164-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _____ day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 3, 2011, XXXXXX, on behalf of herself and her husband XXXXXX (Petitioners), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on May 10, 2011.

The Petitioners receive health care benefits under a certificate of coverage issued by Blue Cross Blue Shield of Michigan (BCBSM). The Commissioner notified BCBSM of the external review and asked for the information it used to make its adverse determination. The Commissioner received BCBSM's response on May 18, 2011.

The issue in this external review can be decided by a contractual analysis. The contract that defines the Petitioners' health care benefits is BCBSM's *Flexible Blue II Individual Market Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioners' coverage with BCBSM was effective on January 15, 2011. Between February 11, 2011 and February 16, 2011, the Petitioners had physical examinations and received preventive services including preventive exams, lab work, x-rays, and an electrocardiogram. The

total amount charged for their care was $1,985.32. BCBSM denied coverage for this care, stating it was provided during the 90-day waiting period before coverage for preventive services began.

The Petitioners appealed BCBSM's denial. BCBSM held a managerial-level conference and issued a final adverse determination on April 6, 2011, upholding its denial.

III. ISSUE

Is BCBSM required to cover the Petitioners' February 2011 preventive services?

IV. ANALYSIS

Petitioner's Argument

The Petitioners state they applied for BCBSM coverage in December 2010. They received their BCBSM cards the next month but had no information about the benefits. They called BCBSM since they had scheduled physicals and were told that preventive care was a covered benefit if network providers were used.

Both the doctor's office and the Petitioners called BCBSM again to confirm their physicals and related care were covered benefits. In March, they received bills from the doctor and the lab that provided their services.

The Petitioners called BCBSM and were told they have a 90-day waiting period for preventive services. They indicate this was the first time they were told of this provision. Had they been aware of this they would have waited for the waiting period to have expired.

The Petitioners argue that BCBSM's customer service representative should have told them during the many telephone calls about the 90-day waiting period. They want BCBSM to reimburse them for the examinations and related care.

BCBSM's Argument

BCBSM states it denied coverage for the examinations and related care because they were preventive care services performed within the first 90 days of the Petitioners' coverage. The certificate, on page 1.6, provides:

> Preventive care benefits will not be subject to the 180-day pre-existing condition waiting period. However, preventive care benefits are subject to a 90-day waiting period from the effective date of your coverage. This waiting period is waived when the member has proof of prior creditable coverage.

Under this provision, no preventive care would be covered until 90 days after the date the Petitioners' coverage was effective, i.e., April 15, 2011.

BCBSM states its documentation of the February 14 and February 22, 2011, telephone calls shows that the Petitioners inquired about benefits for a colonoscopy and were advised colonoscopies are paid at 100% of the approved amount. Information which BCBSM states is correct. However, BCBSM indicates there is no record that the Petitioners asked if there is a waiting period for coverage. BCBSM argues that it is the Petitioners' responsibility to be aware of the terms and conditions of coverage, which in this case called for a 90-day waiting period for preventive benefits. Because the services took place within the 90-day waiting period BCBSM believes it is not required to cover this care.

Commissioner's Review

Preventive care is not a benefit for the first 90 days after coverage is effective. There is no dispute that the Petitioners' February 11 to February 16, 2011, physical examinations and related care were preventive services nor is it in dispute that the services were performed within that 90-day period. Therefore, under the terms of the certificate the services are not covered.

The Petitioners believe that BCBSM gave them incorrect information over the telephone that led them to believe their preventive care would be covered. BCBSM disputes that contention. Under the Patient's Right to Independent Review Act (PRIRA), the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law. Resolution of the dispute described by Petitioners cannot be part of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds that BCBSM correctly applied the terms of the certificate when it denied coverage for the Petitioners' February 2011 preventive care.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of April 6, 2011, is upheld. BCBSM is not required to provide coverage for the Petitioners' February 2011 preventive services.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner